		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029	(X2) M A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE (COMPL 06/19/	ETED
	ROVIDER OR SUPPLIER			5600 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST		
COMMUNITY NURSING AND REHABILITATION CENTER				INDIAN.	APOLIS, IN 46218		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	D TO THE APPROPRIATE	
	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	BEIGEROT		DATE
K0000	A Life Safety Co State Licensure S the Indiana State accordance with Survey Date: 06 Facility Number: Provider Number: AIM Number: 1 Surveyor: Mark Code Specialist At this Life Safet Community Nurs Center was found Requirements for Medicare/Medica 483.70(a), Life S 2000 Edition of the Protection Assoc Safety Code (LS) Health Care Occi 16.2. This two story father of Type II (11 sprinklered. The system with smo	ode Recertification and Survey was conducted by Department of Health in 42 CFR 483.70(a). //19/12 : 000012 r: 155029 00274900 Caraher, Life Safety ty Code survey, sing and Rehabilitation d not in compliance with r Participation in aid, 42 CFR Subpart safety from Fire and the	KOO				DATE
		at sleeping rooms except					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 01	(X3) DATE COMPL		
		155029	A. BUI B. WIN	LDING		06/19/	
MANGOTT	ADOLADED OF CLASS	<u> </u>	P. WIIN		DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	PROVIDER OR SUPPLIER				16TH ST		
COMMUI	NITY NURSING AN	ID REHABILITATION CENTER		INDIAN	APOLIS, IN 46218		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		33 through 141 and 233		mo	·		DATE
		e facility has a capacity					
	-	census of 107 at the time					
	of this visit.						
		Robert Booher, Life Safety					
	Code Specialist-Me	dical Surveyor on 06/21/12.					
	The facility was	found not in compliance					
	-	entioned regulatory					
	requirements as	evidenced by the					
	following:						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029 NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER		(X2) MU A. BUIL B. WING	DING STREET A 5600 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46218	(X3) DATE : COMPL 06/19/	ETED	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0015 SS=E	Interior finish for corridors or interior surfaces movable walls, ceilings, has a for Class B. (In flame spread ra Class C may be rooms separate from the access 19.3.3.2 Based on observing facility failed to the flame spread materials install breakroom and Supervisor's off practice could a visitor in the vice breakroom or the Supervisor's off Findings included Based on observing Maintenance Suthe facility from on 06/19/12, the the employee breakroom and supervisor's off waintenance Suthe facility from on 06/19/12, the employee breakroom and supervisor's off waintenance Suthe facility from on 06/19/12, the employee breakroom and supervisor supervisor's off waintenance Suthe facility from on 06/19/12, the employee breakroom and supervisor	vation and interview, the provide documentation of a rating for interior finish ed in the employee the Housekeeping ice. This deficient any resident, staff or cinity of the employee e Housekeeping ice.	K00	15	It is the practice of this provider to ensure that all interior finish for rooms and spaces not used for corridor or exit ways, including exposed interior surfaces of building such as fixed or movable walls. Partitions, columns, and ceilings, has a flame spread rating of Class or Class B. What corrective action(s) will be taken for the residents found to have been affected by the deficient practice? The entire wall separating the employee breal room and the Housekeeping Supervisor's office has been treated with flame retardant material from the floor to the ceiling. There is documentatio available for review for flame rating. How will you identify other residents having the potential to be affected by the same deficient practice? All residents who reside in the fact have the potential to be affected.	A e e c c c c d c d c d c d c d d c d d d d	07/19/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155029	B. WING		06/19/2012
				ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹		ET ADDRESS, CITT, STATE, ZIF CODE	
CONANALII	NITY NI IDOING AN	ID REHABILITATION CENTER		ANAPOLIS, IN 46218	
COMMO	NITT NURSING AN	ID REHABILITATION CENTER	וטאו	ANAPOLIS, IN 46216	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	floor to ceiling in	n the Housekeeping		by this alleged deficient pract	
	Supervisor's offi	ce. Based on interview at		What measures will be put	:
	the time of the o			into place or what systemic	
		-		changes will you make to	
		pervisor stated neither		ensure that the deficient	
		eated with flame retardant		practice does not recur?	
		nowledged no flame		Maintenance Director has been in conviced and advected an	en
	^ ~	cumentation was		in-serviced and educated on assuring that all interior finish	for
	available for rev	iew for the wood		rooms and spaces not used for	
	paneling or the v	vinyl coated cork board.		corridors or exit ways, including	
		, and the second		exposed interior surfaces of	
	3.1-19(b)			buildings such as fixed or	
	3.1 17(0)			movable walls,	
				partitions, columns, and ceiling	gs,
				has a flame spread rating of	
				Class A or Class B.	
				Maintenance Director or designation	gnee
				will do an audit of all interior finishes ensuring they have	
				documentation of flame rating	1
				How will the corrective)·
				action(s) be monitored to	
				ensure the deficient practice	
				will not recur, i.e. what quali	
				assurance program will be p	_
				into place? The CQI commi	
				will review the results of the a	udit
				conducted by the Maintenand	
				Director/designee for complia	
				If compliance is not achieved	
				action plan will be developed	
				ensure compliance. Date	OT
				Compliance 7/19/12	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE O1 COMPLETED					
ANDILAN	or connection	155029	A. BUILDING			06/19/	
		100020	B. WIN		A DDDDGG GUTY GTATE TID GODE	00/10/	2012
NAME OF P	PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE 16TH ST		
COMMUI	NITY NURSING AN	D REHABILITATION CENTER			APOLIS, IN 46218		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
K0029 SS=E	One hour fire rate fire-rated doors) fire extinguishing 8.4.1 and/or 19.3 areas. When the extinguishing system are self-closing a protective plates inches from the begin permitted. 19.3 Based on observation facility failed to discriving hazardou kitchen are provilatching device to door frame. This affect any resident vicinity of the two from the Main Defloor. Findings include Based on observation of the facility from on 06/19/12, the from the Main Defloor are each not positive latching into the door frame.	ation and interview, the ensure 2 of 14 doors as areas such as the ded with a positive to latch each door into the stafficient practice could not, staff or visitor in the to kitchen entry doors ining Room on the first	K00	029	It is the practice of this provider to ensure that One hour fire rated construction of an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from oth spaces by smoke resisting partitions and doors. Doors a self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door a permitted. What corrective action(s) will be taken for the residents found to have been affected by the deficient practice? All doors serving hazardous areas such as the kitchen are provided with a positive latching device to latcle each door into the door frame. How will you identify other	er are are	07/19/2012

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/19/2012	
	PROVIDER OR SUPPLIEI	R ID REHABILITATION CENTER	5600 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST NAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	2.112
	the two kitchen of Dining Room or equipped with a	pervisor acknowledged entry doors from the Main in the first floor were not positive latching device or into the door frame.		residents having the potentiato be affected by the same deficient practice and what corrective action will be take All residents have the potent to be affected by the alleged deficient practice. What measures will be put into plator what systemic changes we you make to ensure that the deficient practice does not recur? Maintenance Director has been in-serviced on assurt that all doors protecting hazardous areas have a positilatching device to latch each of into the door frame. Maintenance Director/Designed will make rounds weekly x 4 at then monthly thereafter to ensual doors latch to the door frame. How the corrective action(s) will be monitored to ensure the deficient practice will not recibe. What quality assurance program will be put into place. The CQI committee will reviet the results to make sure all do protecting hazardous areas lated door frames for compliance compliance is no achieved, an action plan will be developed the ensure compliance. Date of Compliance 7/19/12	n? ial ce ill ing ve loor ee nd ure ne. he cur, e? w ors tch . If

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	ETED
		155029	B. WIN			06/19/2012	
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER		5600 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46218		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)	-	IAG	DEFICIENCE		DATE
K0038 SS=E	NFPA 101 LIFE SAFETY C Exit access is an readily accessibly with section 7.1. Based on observer facility failed to egress through 1 locks in the facility for residents, state 7.2.1.6.1, Delayed approved, listed, shall be permitted serving low and in buildings protection system with Section 9.6, supervised autominstalled in accordand where permit through 42, prover process shall release device residents.	ation and interview, the ensure the means of of 10 delayed egress ity was readily accessible eff and visitors. LSC ed Egress Locks, says delayed egress locks d to be installed on doors ordinary hazard contents ected throughout by an vised automatic fire installed in accordance	K00	TAG 238	It is the practice of this provider to ensure exit access is arranged so that exits are readily accessible at alltimes accordance with section 7.1. What corrective action(s) will be takenfor those resider found to have been affected by the deficient practice? The from the deficient practice? The from the deficient practice and the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. When the potential to be affected by the alleged deficient practice. When the potential to be affected by the alleged deficient practice. When the potential to be affected by the alleged deficient practice does not recur? Maintenance Director win-serviced on assuring all door in-serviced on assuring all door in-serviced on assuring all door in the deficient practice of the same deficient practice does not recur? Maintenance Director win-serviced on assuring all door in the same deficient practice does not recur?	in nts by ont its you ng y nd c	DATE 07/19/2012
	required to be co	ntinuously applied for			equipped with delayed egress locks are readily accessible for		
	release process signal in the vicin the door lock has application of for device, relocking means only. Except	ands. The initiation of the hall activate an audible nity of the door. Once a been released by the rece to the releasing a shall be by manual ception: Where approved thaving jurisdiction, a			residents, staff and visitors. Maintenance staff will test all doors equipped with delayed egress locks weekly x and monthly thereafter to assulocks will release within 15 seconds of applying force. Howill the corrective action(s) where monitored to ensure the	4 re w	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155029	B. WIN	G		06/19/2012
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE	
COMMU	NITV NILIDOINIC AN	ID REHABILITATION CENTER			16TH ST APOLIS, IN 46218	
					AF OLIS, IN 402 10	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	(X5) COMPLETION	
TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
		ling 30 seconds shall be			deficient practice will not rec	
	permitted.	mig 50 seconds shan oc			i.e. what quality assurance	,
	1 *	actice could affect any			program will be put into	
	_	visitor wanting to exit			place? The CQI committee wi	l l
	•	g the Front Lobby exit.			review the results of the egres locks conducted by the Director	l l
		,			Maintenance/Designee for	
	Findings include	: :			compliance. If compliance is n	
					achieved, an action plan will b developed to ensure	e
	Based on observ	ation with the			compliance. Dateof Compliance	ce
	Maintenance Sur	pervisor during a tour of			7/19/12	
	the facility from 11:25 a.m. to 1:45 p.m.					
		Front Lobby exit door is				
	equipped with a	delayed egress lock				
	which was provi	ded with signage stating				
	the door could b	e opened in 15 seconds				
	by pushing on th	e door release device, but				
	the exit door did	not release within 15				
	seconds when th	e door was pushed with				
	the application o	f force five separate				
		interview at the time of				
		Maintenance Supervisor				
	_	ne Front Lobby exit door				
		a delayed egress lock				
	_	ded with signage stating				
		e opened in 15 seconds				
		e door release device, but				
		not release within 15				
		e door was pushed with				
		of force five separate				
	times.					
	2.1.10(1)					
	3.1-19(b)					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029		A. BUILDING B. WING			COMPLETED 06/19/2012		
		ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 06/19/2012			ETED		
COMMUI		D REHABILITATION CENTER		STREET A 5600 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0046 SS=F	Emergency lighting duration is provided as a considerate with battery operated 7.9.3 Periodic Telegibring Equipments to be conducted and an annual test every required be emergency lighting than 1½ hour durates. Written receased and tests shall be inspection by the jurisdiction. This affect all resident Findings include Based on review Emergency Light documentation we Supervisor during 9:25 a.m. to 11:2 documentation of conducted at 30 deleven battery operated.	LSC 7.9 for 11 of 11 emergency lights. LSC esting of Emergency ent requires a functional ted at 30 day intervals est to be conducted on eattery powered ing system for not less ration. Equipment shall hal for the duration of the ords of visual inspections except by the owner for eauthority having est deficient practice could ests, staff and visitors.	K00	46	It is the practice of this provider to ensure that emergency lighting of atleas ½ hour duration is provided accordance with 7.9. What corrective action(s) will be taken for those residents for to have been affected by the deficient practice? All emergency lighting equipment and batteries have been teste ensure that emergency lighting will be fully operational for not less than a 1½ hour duration. How will you identify other residents having the potentiat to be affected by the same deficient practice? All resident have the potential to be affect by this alleged deficient practice by this alleged deficient practice. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur? Maintenance Director/Designee was in-serviced by the Executive Director on assuring that there periodic testing of emergency lighting equipment on 30 day intervals and an annual test who conducted on every require battery powered emergency lighting system for not less that ½ hour duration. How the	in Ind It do to g Ints ed cce. Into	07/19/2012

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	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029		01	COMPLETED 06/19/2012
	PROVIDER OR SUPPLIER NITY NURSING AND REHABILITATION CENTER	5600 E 1	DDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	period of June 2011 through December 2011. Documentation of annual testing of each battery powered emergency lighting system for not less than 1 ½ hour duration was not available for review for the period of June 2011 through May 2012. Based on observations with the Maintenance Supervisor during a tour of the facility from 11:25 a.m. to 1:45 p.m. on 06/19/12, there are eleven battery operated emergency lights located in the facility. Based on interview at the time of record review, the Maintenance Supervisor stated each battery operated emergency light is tested on a monthly basis but acknowledged documentation was not available for review of the thirty day interval testing for the period of June 2011 through December 2011, and annual testing for each of the eleven battery operated emergency lights in the facility for the period of June 2011 through May 2012. 3.1-19(b)		corrective action(s) will be monitored to ensure the deficient practice will not redie. what quality assurance program will be put into place. The CQI Committee led by the Executive Director will revithe results of emergency lighting equipment and battery powers emergency lighting system test to ensure compliance. Date of Compliance 7/19/12	e? ew ng ed sts

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		155029	B. WING		06/19/2012
	PROVIDER OR SUPPLIEI	R ID REHABILITATION CENTER	5600 E	ADDRESS, CITY, STATE, ZIP CODE E 16TH ST NAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0048 SS=E	There is a writte patients and for of an emergency Based on record facility failed to fire extinguisher safety plans for requires written fire safety plans following: (1) Use of alarm (2) Transmission department (3) Response to (4) Isolation of following: (5) Evacuation of following: (6) Evacuation of following: (7) Preparation of evacuation of following: (8) Extinguishm This deficient program: staff and the kitchen. Findings included Based on review Fire Prevention' Program: Fire Endocumentation of the Maintenance a.m. to 11:25 a.m.	review and interview, the include the use of kitchen is in 1 of 1 written fire the facility. LSC 19.7.2.2 health care occupancy shall provide for the sent of alarm to the fire alarms fire of immediate area of smoke compartment of floors and building for ent of fire factice affects any did visitor in the vicinity of section of "Disaster Action Plan: and "Emergency Action"	K0048	It is the practice of this provider to ensure that there a written plan for the protect of all patients and for their evacuation in the event of an emergency. What corrective action(s) will be taken for the residents found to have been affected by the deficient practice? The fire safety plan addresses the use of ABC typ fire extinguishers and the K-C fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The Emergency Action Plan includ a policy to activity the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K-class fire extinguisher. How will you identify other residents having the potential to be affected by the same deficient practice as what corrective action will be taken? All residents who resident the facility have the potential be affected by this alleged deficient practice. What measures will be put into plator what systemic changes we you make to ensure that the deficient practice does not recur? The Maintenance	e e e e e e e e e e e e e e e e e e e

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/19/2012	
	PROVIDER OR SUPPLIER	L R ID REHABILITATION CENTER	STREET 5600 E	ADDRESS, CITY, STATE, ZIP COE E 16TH ST NAPOLIS, IN 46218	
	SUMMARY S (EACH DEFICIEN REGULATORY OR address the use of extinguishers and extinguisher local relationship with overhead extinguisher with the written fire shaded overhead hood esuppress a fire browness.	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL ELSC IDENTIFYING INFORMATION) of ABC type fire d the K-class fire ated in the kitchen in the use of the kitchen uishing system. Based on time of record review, the pervisor acknowledged afety plan for the facility he policy to activate the extinguishing system to efore using either the ktinguisher or the K-class	5600 E	16TH ST	crition (X5) COMPLETION DATE eck all so 1 x in the hace. an e ression K-Class practices waste addord derly, torage. so away cources units, allights, e of ration so need not of plastic effore gof ds in ers in so B able pols. stibles soline so and d gas and rosol ces for clude: A. ttainers,
				storage, handling and us Class B Combustibles (i.	

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155029	B. WING		06/19/2012
(F. 6F. F		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	K	5600 E	16TH ST	
COMMUI	NITY NURSING AN	ND REHABILITATION CENTER	INDIAN	APOLIS, IN 46218	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)	TAG		DATE
				thinner or gasoline will not be	
				stored in unauthorized plastic	
				containers).B. Assuring all	
				respective containers are	
				conspicuously and accurately labeled as to their contents.	
				Material Safety Data information	on
				included in labeling as	
				required.C. Liquid from tanks,	
				drums or barrels will be	
				dispensed by use of approved	
				pumps or self-closing valves o	
				faucets.D. Class B combustib	
				will be stored only in the areas	
				where vapors cannot reach an	ly
				source of ignition. Highly flammable combustibles such	20
				solvents and gasoline products	
				will not be stored in buildings t	
				are licensed or comprehensive	
				nursing care or other buildings	
				used as residence. The	
				Maintenance Department is	
				responsible for assuring all ite	ms
				are appropriately stored and	
				labeled.E. Class B combustib	
				will not be used for any cleaning	ng
				procedure inside a building except in a closed machine	
				approved for that purpose.F.	
				Class B combustibles will not I	oe l
				used in or near exits, stairways	
				other normal egress locations.	
				The use and storage of all Cla	
				B combustibles will be reported	d to
				the Maintenance Director and	
				approved for use. H. Gasoline	
				powered vehicles will be store	a
				outdoors in approved garage	t he
				areas.I. All oxygen tanks mus turned OFF when not in use by	
				the resident. 3. Class C	y
				2.3 (30)30.71. 0. 0.000	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155029	A. BUILDING B. WING		01	COMPLETED 06/19/2012	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE 16TH ST		
COMMU	NITY NURSING AN	D REHABILITATION CENTER			APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
					combustibles include all electrical current (i.e. appliance machinery, electrical outlets, cords, etc.). Safety Practices Class C Combustibles include Frequent inspection of equipme plugs and wires to ensure integrity. Avoid pulling on wire disconnect plug from wall outlet.B. Electrical equipment be placed and used at a safe distance from Class A and B combustibles, with clearances conformance with manufacture instructions.C. Fused powers cords approved by the Maintenance Director may be used for non-medical equipmed. Location for use as well as typ cord must be approved.D. Electrical receptacles and circum will not be overloaded by use outlet adapters.E. The Maintenance Department will be promptly notified of any defect wall outlets, outlet plate covers frayed wiring.F. All appliances including but not limited to televisions, radios, electric raz microwaves, fans or heaters, emust be presented to the Maintenance Director for inspection upon arrival at the facility for residents or facility use.G. The use of extension cords in lieu of permanent wiritis prohibited. Space heaters mot be used in any area of the facility. How the corrective action(s) will be monitored to ensure the deficient practice	es, for : A. ient to will in er's strip ent. e of uits of oe ive s or s, ors, etc.	

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Event ID: VPZ121

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PRINTED: 07/06/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155029	(X2) MULTIPLE CO A. BUILDING B. WING	01		LETED 0/2012		
	ROVIDER OR SUPPLIE	R ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETION DATE		
				will not recur, i.e. what assurance program will into place?The CQI Cor led by the Executive Dire review the results of Disa Plans to ensure complian of Compliance 7/19/12	quality I be put mmittee ector will aster			

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Event ID: VPZ121

Facility ID: 000012

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	O1 COMPI			(X3) DATE S COMPL	
		155029	A. BUII B. WIN			06/19/	2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			5600 E	16TH ST		
COMMU	NITY NURSING AN	D REHABILITATION CENTER		INDIAN	APOLIS, IN 46218		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
		ESC IDENTIFICATION OR MATTERY		1710	<u> </u>		DATE
K0050 SS=F	NFPA 101 LIFE SAFETY Corrier drills are hell varying condition shift. The staff is and is aware that routine. Respon conducting drills competent person exercise leaders conducted between announcement in audible alarms. 1. Based on record the facility failed conducted on the for 2 of 4 quarter affects all occupatincluding resident. Findings include Based on review Report" document Maintenance Superview from 9:25 06/20/12, there is available for review conducted on the quarter of 2011 at the fourth quarter of the transport of	ODE STANDARD d at unexpected times under is, at least quarterly on each is familiar with procedures it drills are part of established sibility for planning and is assigned only to ons who are qualified to hip. Where drills are seen 9 PM and 6 AM a coded may be used instead of 19.7.1.2 ord review and interview, at to document fire drills is second and third shift is. This deficient practice ants in the facility ints, staff and visitors. The of "Monthly Fire Drill intation with the previsor during record is a.m. to 11:25 a.m. on is no documentation.	K00		It is the practice of this provider to ensure fire drills a held at unexpected times und varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting dril is assigned only to competer persons who are qualified to exercise leadership. Where drills are conducted between 9PM and 6AM a coded announcement may be used instead of audible alarms. With corrective action(s) will be taken for those residents four to have been affected by the deficient practice? An in-service was conducted with the Maintenance Director/Designet to ensure fire drill performed as	der is is nat nd ice	07/19/2012
	review of a fire d	umentation available for lrill being conducted on for the third quarter of			unexpected and are at least conducted at least conducted quarterly on each shift. An in-service was conducted with	the	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	01	COMPLE	TED
		155029	A. BUII B. WIN			06/19/2	012
			D. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			16TH ST		
COMMU	NITV NI IDQING AN	ID REHABILITATION CENTER			APOLIS, IN 46218		
		ND REHABILITATION CENTER		INDIAN	AFOLIS, IN 402 16		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
		third shift for the fourth			Maintenance Director/Designe	ee	
	quarter of 2011.				by the Executive Director to ensure all fire drills conducted	will	
					include the transmission of the		
	3.1-19(b)				fire alarm signal and simulation		
					emergency fire conditions. Ho		
	2. Based on record review and interview,				will you identify other reside		
					having the potential to be		
		d to document the			affected by the same deficier	nt	
		the fire alarm signal for 1			practice? All residents who		
		onducted prior to 9:00			receive laboratory services wh	10	
		shift for 1 of 4 quarters.			reside in the facility have the		
	LSC 19.7.1.2 sta	ites fire drills in health			potential to be effected by the	n4	
	care occupancies	s shall include the			alleged deficient practice. W measures will be put into pla		
	transmission of t	the fire alarm signal and			or what systemic changes w		
		nergency fire conditions.			you make to ensure that the	"	
	This deficient pr				deficient practice does not		
	residents, staff a				recur? A fire drill schedule wa	as	
	residents, stari a	ild visitors.			developed to ensure fire drills		
					conducted are at unexpected		
	Findings include	2:			times and under varying		
					conditions and include		
	Based on review	of "Monthly Fire Drill			the transmission of the fire ala	ırm	
	Report" docume	ntation during record			signal and simulation of emergency fire conditions. Ho	ow	
	review with the	Maintenance Supervisor			the corrective action(s) will b		
	from 9:25 a.m. to	o 11:25 a.m. on 06/19/12,			monitored to ensure the		
		or the first shift fire drill			deficient practice will not rec	ur,	
		/17/12 at 9:30 a.m. did			i.e. what quality assurance	·	
		ransmission of the fire			program will be put into plac	e?	
					The CQI Committee lead by t		
		ritten documentation of			Executive Director will review	the	
		ed "No" in response to			results of the fire drill for		
		that the monitoring			compliance. If compliance is n achieved, an action plan will b		
	service received	the alarm?" Based on			developed to ensure complian		
	interview at the	time of record review, the			Date of Compliance 7/19/12		
	Maintenance Sur	pervisor acknowledged					
		of the first shift fire drill					
		/17/12 at 9:30 a.m. did					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01		ESURVEY LETED 0/2012		
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	not include transsignal.	mission of the fire alarm						
	3.1-19(b) 3. Based on recording the facility failed documented fire transmission of a monitoring comprometer for the third shift requires fire drill occupancies shall transmission of a deficient practice staff and visitors Findings include Based on review Report" documenter with the Month of the from 9:25 a.m. to documentation for conducted on 06, not include the tralarm signal. The	drills included the a fire alarm signal to the pany for 1 of 4 quarters at NFPA at 19.7.1.2 in health care a linclude the a fire alarm signal. This is affects all residents, affects affects all residents, affects all residents, affects affects all residents, affects affects all residents, affects affects all residents,						
	the fire alarm sig company during before, or the day	rding the transmission of gnal to the monitoring the fire drill, the day y after the third shift fire interview at the time of						

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	OF CORRECTION IDENTIFICATION NUMBER: 155029	A. BUILE B. WING		<u>01</u>	COMPL 06/19/	ETED	
	PROVIDER OR SUPPLIER NITY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	Supervisor stated fire drills conducted on the third shift do not include transmission of the fire alarm system signal during the fire drill or the day before or after the third shift fire drill and acknowledged transmission of the fire alarm system signal is not documented on the 06/11/11 "Monthly Fire Drill Report". 3-1.19(b)						

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLI	ETED
		155029	B. WIN			06/19/	2012
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L		5600 E	16TH ST		
COMMUI	NITY NURSING AN	D REHABILITATION CENTER		INDIAN	APOLIS, IN 46218		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG K0064	NFPA 101	LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCI)		DATE
SS=F	LIFE SAFETY C Portable fire extinealth care occu 9.7.4.1. 19.3.5 Based on observa	ODE STANDARD nguishers are provided in all pancies in accordance with 5.6, NFPA 10 ations and interview, the inspect 7 of 16 portable	K00	064	It is the practice of this provider to ensure that all		07/19/2012
	_	s for 4 of 12 months. ard for Portable Fire			portable fire extinguishers are provided in all health care		
	•	ection 4-3.4.2 requires			occupancies in accordance with 9.7.4.1. What corrective		
	fire extinguisher	inspections at least			action(s) will be taken for tho	se	
	monthly with the	e date of inspection and at			residents found to have been	1	
	least the initials of	of the person performing			affected by the deficient practice? All portable fire		
	the inspection be	ing recorded. In			extinguishers have been		
	addition, NFPA	10, Section 4-2.1 defines			inspected. How will you iden	tify	
	inspection as a "o	quick check" to ensure a			other residents having the		
	fire extinguisher	is available and will			potential to be affected by the	е	
	operate. It is into	ended to give reasonable			same deficient practice and what corrective action will be	,	
	assurance the fire	e extinguisher is fully			taken? All residents have the		
	charged and oper	rable, verifying it is in its			potential to be affected by the		
	designated place	, it has not been actuated			alleged deficient practice. Wh		
	or tampered with	, and there is no obvious			measures will be put into pla		
	or physical dama	age or condition to			or what systemic changes wi you make to ensure that the	111	
	prevent its opera	tion. This deficient			deficient practice does not		
	practice affects a	ll residents, staff and			recur? Maintenance		
	visitor in the faci	ility.			Director/Designee will be	,	
					in-serviced by Executive Direc	tor	
	Findings include	:			to ensure that all portable fire extinguishers are inspected at		
					least 1 x monthly with the date		
	Based on observa	ations with the			the inspection and atleast the		
	Maintenance Sup	pervisor during a tour of			initials of the person performin	g	
	the facility from	11:25 a.m. to 1:45 p.m.			the inspection recorded. All portable fire extinguishers with	_{nin}	
	on 06/19/12, the	most recent documented			facility will be inspected 1 x		
	monthly inspecti	on on inspection tags			monthly with the date of		
	affixed to the fol	lowing portable fire			inspection and atleast the initia	als	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	01	COMPL	ETED
		155029		LDING		06/19/	2012
			B. WIN		ADDRESS CONT. STATE SID CODE		_
NAME OF I	PROVIDER OR SUPPLIE	CR.			ADDRESS, CITY, STATE, ZIP CODE		
0011111	NUTY AU IDOING A	NE DELLA BILLEA TION OF LITER			16TH ST		
COMMU	NITY NURSING A	ND REHABILITATION CENTER		INDIAN	APOLIS, IN 46218		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	extinguishers w	as:			of the person performing the		
	_	for the fire extinguisher			inspection being recorded. Ho	w	
	1	nd floor by the MDS			the corrective action(s) will b	е	
					monitored to ensure the		
	Coordinator's O				deficient practice will not red	ur,	
	_	or the fire extinguishers			i.e. what quality assurance		
	located on the f	irst floor by Room 123,			program will will be put into	Γhe	
	Room 130 and	Room 140.			CQI Committee led by the	41	
	c. March 2012 f	for the fire extinguishers			Executive Director will review results of the fire extinguisher		
		irst floor by the Activities			inspection results. If compliance		
		eeping Office and by			is not achieved, an action plan		
	Room 116.	ceping office and by			be developed to ensure		
					compliance. Date of Complian	nce	
		iew at the time of the			7/19/12		
		e Maintenance Supervisor					
	stated no other	documentation of monthly					
	inspections was	available for review and					
	acknowledged i	oortable fire extinguishers					
		tioned locations did not					
		ed monthly inspections for					
	-	bruary 2012 through May					
	2012.						
	3.1-19(b)						
	I						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155029	B. WIN			06/19/	/2012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER				16TH ST		
COMMUN	NITY NURSING AN	D REHABILITATION CENTER			APOLIS, IN 46218		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
K0069 SS=E	Cooking facilities with 9.2.3. 19. 1. Based on reco	ODE STANDARD s are protected in accordance 3.2.6, NFPA 96 ord review, observation	K0069		It is the practice of this provider to ensure that the cooking facilit		07/19/2012
	· · · · · · · · · · · · · · · · · · ·	e facility failed to ensure			is protected in accordance with	,	
	1 of 1 kitchen ex	haust systems was			9.2.3.		
	cleaned at least s	emiannually. NFPA 96,					
	1998 Edition, Sta	andard for Ventilation			What corrective action(s) will be taken for those residents found		
	Control and Fire	Protection of			have been affected by the deficie		
	Commercial Coo	oking Operations, 8-3.1			practice?		
		grease removal devices,			The distance and acceptance and		
		other appurtenances shall			The kitchen exhaust system was cleaned and the hood extinguishing	na	
		re metal at frequent			system was inspected and service		
		surfaces becoming					
	-	nated with grease or oily			How will you identify other residents having the potential to		
	•	e exhaust system is			be affected by the same deficien		
	•	•			practice?		
		netal, it shall not be				h -	
	•	der or other substance.			All residents have the potential to affected by the alleged deficient	be	
		st system shall be			practice.		
		roperly trained, qualified,			L		
		npany or person(s) in			What measures will be put into place or what systemic changes		
		Table 8-3.1. Table 8-3.1			will you make to ensure that the		
	requires systems	serving moderate			deficient practice does not recur	?	
	•	operations shall be			Maintanana Bi 1 /D 1		
	inspected semian	nually. This deficient			Maintenance Director/Designee was be in-serviced by Executive Directory		
	practice could af	fect any resident, staff or			to ensure that the kitchen exhaus		
	visitor in the vici	nity of the kitchen.			system is cleaned semi-annually.		
	Findings include				Maintenance Director/Designee was be in-serviced by Executive direct to ensure that the kitchen extinguishing system is inspected	tor	
	Based on record				and serviced 1 x every 6 months.		
	•	pervisor from 9:25 a.m.			How the corrective action(c) will		
	to 11:25 a.m. on	06/19/12,			How the corrective action(s) will be monitored to ensure the		

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	01	COMPLETED
		155029	B. WING			06/19/2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
COMMUI	NITY NURSING AN	D REHABILITATION CENTER			16TH ST APOLIS, IN 46218	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	P:	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	deficient practice will not recur,	DATE
		f semiannual kitchen			i.e. what quality assurance	
	_	ing was not available for			program will be put into place?	
		n observation with the			The COI Committee led by the	
	-	pervisor during a tour of			The CQI Committee led by the Executive Director will review the	
		11:25 a.m. to 1:45 p.m.			kitchen exhaust system after it is	
	· ·	Fire Safety Company			cleaned. If compliance is not achieved, an action plan will be	
		to the kitchen range hood			developed to ensure compliance.	
		hood system was last			The CQI Committee led by the	
	1	2012. Documentation of			Executive Director will review the	
		ning prior to May 2012			results of the hood extinguishing	
		I affixed to the range interview at the time of			inspection. If compliance is not achieved, an action plan will be	
					developed to ensure compliance.	
		d observation, the pervisor acknowledged			Date of Compliance 7/19/12	
	_	f semiannual kitchen			Date of Compliance 1/19/12	
	_	leaning prior to May ailable for review.				
	2012 was not ava	madie for feview.				
	3.1-19(b)					
		ord review and interview,				
		to ensure 1 of 1 hood				
		stems in the kitchen was				
		rviced every six months.				
	· ·	andard for Ventilation				
	Control and Fire					
		oking Operations, Section				
	•	nspection and servicing				
	_	uishing system at least				
		. This deficient practice				
	-	resident, staff or visitor				
	in the vicinity of	the kitchen.				
	Findings include	:				

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	OF CORRECTION IDEN	TIFICATION NUMBER:	A. BUILI B. WING	DING	<u>01</u>	COMPL 06/19/	ETED
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER				5600 E	DDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PERCEDED BY FULL DENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	Based on record reviet Maintenance Supervito 11:25 a.m. on 06/documentation of sen hood extinguishing sy was not available for interview at the time Maintenance Supervisemiannual kitchen hisystem service docum available for review. 3.1-19(b)	sor from 9:25 a.m. 19/12, niannual kitchen system service records review. Based on of record review, the sor acknowledged ood extinguishing					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPL	ETED
		155029	B. WING			06/19/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					16TH ST		
COMMUI	NITY NURSING AN	D REHABILITATION CENTER		INDIAN	APOLIS, IN 46218		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0076 SS=E	Medical gas stor are protected in Standards for He (a) Oxygen stora 3,000 cu.ft. are e separation.	ODE STANDARD age and administration areas accordance with NFPA 99, ealth Care Facilities. age locations of greater than enclosed by a one-hour supply systems of greater are vented to the outside					
	NFPA 99 4.3.1.1	are vented to the outside2, 19.3.2.4 ation and interview, the	K00	176	It is the practice of this		07/19/2012
	facility failed to storage locations cubic feet was er of 1 hour fire resident, staff or the oxygen storaglocated inside the first floor. Findings include Based on observe Maintenance Supthe facility from on 06/19/12, there room located instead inside the first floor. Toxygen storage relabel affixed to the foot by six in the foot of the	ensure 1 of 3 oxygen of greater than 3000 nclosed with a separation istive construction. This e could affect any visitor in the vicinity of ge and transfilling room e Bathing Room on the			provider to ensure that medic gas storage and administratic areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. a) Oxygen storage locations of greater than 3,00 cu. Ft. are enclosed by one—hour separations b) Locations for supply systems of greater than 3,000 cu.ft are vented to the outside. What corrective action(s) will be taken for those residents fou to have been affected by the deficient practice? The door the oxygen storage room on the first was replaced with a door to provided one hour fire resistive construction. How will you identify other residents having the potential to be affected by the same deficient practice? residents have the potential to affected by the alleged deficient practice. What measures will put into place or what system	on on on on on on on on on on	07/19/2012

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	of correction identification number: 155029	A. BUILDING B. WING	01	COMPLETED 06/19/2012
СОММИ	PROVIDER OR SUPPLIER NITY NURSING AND REHABILITATION CENTER	5600 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	oxygen tanks were observed in the room. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the entry door to the oxygen storage room did not provide one hour fire resistive construction. 3.1-19(b)		changes will you make to ensure that the deficient practice does not recur? Maintenance Director/Designe will be in-serviced by Executiv Director to ensure that all oxy storage locations greater than 3,000 cu.ft.are enclosed with separated with a one hour fire resistive construction. Maintenance Director/Designe will do monthly rounds to ensure that oxygen storage areas are appropriately separated from other portions of facility. How the corrective action(s) will monitored to ensure the deficient practice will not recise. what quality assurance program will be put into place?The CQI Committee lethe Executive Director will revisely storage locations. If compliant not achieved, an action plan where developed. Date of Compliance 7/19/12	ye gen gen a a e ee ure e b cur, d by iew n ce is

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029		(X2) MU A. BUII B. WIN	LDING G	ONSTRUCTION 01	(X3) DATE : COMPL 06/19/	ETED	
	PROVIDER OR SUPPLIER	D REHABILITATION CENTER		5600 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46218		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
K0143 SS=E	(a) separated frowherein patients treated by a separated from the immediate and accordance with Compressed Garage and of oxygen storage and foxygen takes any portion of a are housed, exam separation of a firesistive construction of a fir	om any portion of a facility are housed, examined, or aration of a fire barrier of ive construction; at is mechanically ventilated, has ceramic or concrete sted with signs indicating that courring, and that smoking in rea is not permitted in NFPA 99 and the s Association. 8.6.2.5.2 ation and interview, the ensure 1 of 3 liquid areas where transferring place was separated from facility wherein residents mined, or treated by a are barrier of 1 hour fire cition. This deficient effect any resident, staff or inity of the oxygen stilling room located ag Room on the first	K01	43	It is the practice of this provider to ensure that transferring oxygen is: a) Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barri of 1-hour fire-resistive construction; b) In an area this mechanically ventilated, sprinklered, and has ceramic concrete flooring; and c) In a area posted with signs indicating that transferring is occurring, and that smoking the immediate area is not permitted in accordance with NFPA 99 and the Compresse Gas Association. What corrective action(s) will be taken for those residents four to have been affected by the deficient practice? The door in the surface of	e der hat cor an d	07/19/2012

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE COMPL - 06/19/	ETED
COMMUN		ID REHABILITATION CENTER	5600 E INDIAN	ADDRESS, CITY, STATE, ZIP CO 16TH ST IAPOLIS, IN 46218	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)		(X5) COMPLETION DATE
				achieved, an action plan developed. Date of Com 7/19/12		
			1			

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Event ID: VPZ121

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029		LDING	ONSTRUCTION 01	(X3) DATE S COMPL 06/19/	ETED
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER			5600 E INDIAN	ADDRESS, CITY, STATE, ZIP CODE 16TH ST IAPOLIS, IN 46218			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0144 SS=F	Generators are in exercised under month in accorda 3.4.4.1. 1. Based on record the facility failed written record of the starting batter generator was may weeks. Chapter requires storage in connection with systems shall be not more than 7 cmaintained in full manufacturer's sploatteries shall be immediately upo Furthermore, NF checking storage electrolyte levels than 7 days. Charequires a writter performance, exercipairs for the gemaintained and a having jurisdiction.	essential electrical inspected at intervals of days and shall be I compliance with pecifications. Defective repaired or replaced in discovery of defects. PA 110, 6-3.6 requires batteries, including at intervals of not more apter 3-5.4.2 of NFPA 99 in record of inspection, excising period, and inerator to be regularly evailable by the authority on. This deficient fect all residents, staff	K01	144	It is the practice of this provider to ensure that the generators are inspected weekly and exercised under load for 30 minutes per monin accordance with NFPA 99 What corrective action(s) will be taken for those residents found to have been affected the deficient practice? The emergency generator starting battery has been inspected. A load test has been conducted the emergency generator. Howill you identify other reside having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice. When measures will be put into plator what systemic changes we you make to ensure that the deficient practice does not recur? Maintenance Director/Designee will be in-serviced by Executive Director a monthly load test is done the emergency generator 1 x monthly. Maintenance Director/Designee will be in-serviced by Executive Director ensure the emergency generator starting battery is	by Indicator Indicat	07/19/2012

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	OF CORRECTION OF CORRECTION 155029	(X2) MULTIPLE CC A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 06/19/2012
	PROVIDER OR SUPPLIER NITY NURSING AND REHABILITATION CENTER	5600 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	Generator-Weekly Inspection Checklist" documentation with the Maintenance Supervisor during record review from 9:25 a.m. to 11:25 a.m. on 06/19/12, weekly emergency generator starting battery inspection records for December 2011 were not available for review. Based on interview at the time of record review, the Maintenance Supervisor acknowledged weekly emergency generator starting battery inspection records for December 2011 were not available for review. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure a monthly load test for 1 of 1 emergency generators was conducted for 3 of 12 months using one of the three following methods: under operating temperature conditions, at not less than 30% of the Emergency Power Supply (EPS) nameplate rating, or loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes,		checked 1 x weekly. How will corrective action(s) be monitored to ensure the deficient practice will not recise. what quality assurance program will be put into place. The CQI Committee led by the Executive Director will review results of the emergency generator tests. If compliance not achieved, an action plan who be developed to ensure compliance. Date of Compliant 7/19/12	cur, ee? ethe is

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155029	B. WIN			06/19/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
000.40.41.11	NUTY NU IDOING AN				16TH ST	
		D REHABILITATION CENTER		INDIAN	APOLIS, IN 46218	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
IAG		LSC IDENTIFYING INFORMATION)		TAG	BEIGENCI	DATE
	~	following methods:				
	_	ng temperature conditions				
		n 30 percent of the EPS				
	nameplate rating					
	_	naintains the minimum				
	exhaust gas temp					
		the manufacturer.				
		e of day for required				
	_ ~	ecided by the owner,				
		operations. NFPA 99,				
	_	a written record of				
		rmance, exercising				
	1 ^ ^	rs shall be regularly				
		vailable for inspection				
	1 -	having jurisdiction. This				
	deficient practice					
	residents, staff a	nd visitors.				
	Findings include	:				
		0.077				
	Based on review	0 5				
		ly Exercise/Monthly				
	_	documentation with the				
	1	pervisor during record				
		5 a.m. to 11:25 a.m. on				
	06/19/12, month	-				
		vas not available for				
	_	eriod of March 2012				
	1 -	12. Based on interview at				
	the time of recor					
	Maintenance Sup	pervisor acknowledged				
	monthly load tes	t documentation was not				
	available for revi	iew for the period of				
	March 2012 thro	ugh May 2012.				

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01		SURVEY LETED 1/2012
	ROVIDER OR SUPPLIER	5600 E	ADDRESS, CITY, STATE, ZIP COI 16TH ST IAPOLIS, IN 46218	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	3.1-19(b)				

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facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 107 of 107 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager provider to ensure that where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? A policy has been written containing procedures that are to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 building is evacuated or an approved fire watch system is provided. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? A policy has been written containing procedures that are to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? A policy has been written containing procedures that are to be followed in the event the automatic sprinkler system is provided. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice?	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER COMMUNITY NURSING AND REHABILITATION CENTER S600 E 16TH ST INDIANAPOLIS, IN 46218	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	01		
COMMUNITY NURSING AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) K0154 NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provider to ensure that where a required automatic sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? A policy has been written containing procedures that are to be followed in the event the automatic sprinkler system is provided to an approved fire watch system is provided. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? A policy has been written containing procedures that are to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided. What corrective action(s) will be taken for those residents found to have been affected by the deficient practice? A policy has been written containing procedures that are to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period. How will you identify other residents having the potential to be affected by the			155029	B. WING			06/19/	2012
RREHX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG					5600 E	16TH ST		
REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	` ′				ID			
NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 107 of 107 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager		`				CROSS-REFERENCED TO THE APPROPRIA	TE	
Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for four hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 107 of 107 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager			LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Fire Watch Policy same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not		LIFE SAFETY C Where a required is out of service 24-hour period, to jurisdiction is not evacuated or an is provided for all the shutdown unbeen returned to Based on record facility failed to written policy confollowed in the elementary system service for four land thour period in acceptance for four land the sprinkler system service for four land the sprinkler impairs with NFPA 25, 1 standard for Insp. Maintenance of Vertical Protection System requires the local notified of sprink 11-5(e) requires alarm company, and other authoricals obe notified. Could affect all revisitors.	d automatic sprinkler system for more than 4 hours in a the authority having tified, and the building is approved fire watch system I parties left unprotected by til the sprinkler system has a service. 9.7.6.1 review and interview, the provide a complete ontaining procedures to be event the automatic has to be placed out of anours or more in a 24 ecordance with LSC, an order to protect 107 of SC 9.7.6.2 requires ment procedures comply 1998 Edition, the spection, Testing and Water-Based Fire ms. NFPA 25, 11-5(d) I fire department be alter impairment and the insurance carrier, building owner/manager ities having jurisdiction. This deficient practice esidents, staff and	K01	54	provider to ensure that where required automatic sprinkler system is out of service for more than 4 hours in a 24-ho period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided. What corrective action(s) will be taken for the residents found to have been affected by the deficient practice? A policy has been written containing procedures are to be followed in the event automatic sprinkler system has be placed out of service for followrs or more in a 24 hour period. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the alleged deficient practice. What measures will be put into pla or what systemic changes will you make to ensure that the	ur ne is ose n that the s to ur	07/19/2012

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	OF CORRECTION OF CORRECTION 155029	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/19/2012
	PROVIDER OR SUPPLIER NITY NURSING AND REHABILITATION CENTER	5600 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST IAPOLIS, IN 46218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	and Procedure" documentation with the Maintenance Supervisor during record review from 9:25 a.m. to 11:25 a.m. on 06/19/12, Procedure 6 states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the necessary entities, which includes the Indiana State Department of Health, alarm company, local fire department, and building owner/manager, would only be notified in the event of a fire. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health, alarm company, local fire department, and building owner/manager in the event the automatic sprinkler system is out of service for four hours or more in a 24 hour period. 3.1-19(b)		recur? The Maintenance Director/Designee will check a disaster manual locations 1 x monthly to ensure all are in th appropriate locations with appropriate policies in place. Watch Policy and Procedure Policy: It is the policy of this Provider to implement a firewa in case of emergency situation which the fire suppression sys and/or the fire alarm system a out of service for a period of ti longer than 4 hours in a 24-ho period. It is the policy of this Provider to implement a firewa at other times as determined it the Executive Director, Director Nursing or Maintenance Director as needed. With the implementation of any Firewa for any justifiable reason, the Executive Director or designe will notify all necessary entitie include a. State Department of Health 317-233-7442 b. Insurance Company (Connor Insurance 317-808-7711 c. Owners (via Director of Operations/C.O.O.) 317-523-4786 d. Security Monitoring Company (Central Security) 317-543-1300 e. Le Fire Department 911 f. Any other necessary entities deem necessary or required by law. How the corrective action(s) will be monitored to ensure deficient practice will not red i.e. what quality assurance program will be put into place The CQI Committee led by the	Fire atch as in stem are me our atch by or of tor tch e s to of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 01			COMPLETED		
		155029	B. WING			06/19/	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					16TH ST		
COMMUNITY NURSING AND REHABILITATION CENTER			INDIANAPOLIS, IN 46218				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	Executive Director will review		DATE
					results of Disaster Plans to ensure compliance. Date of Compliance 7/19/12	uie	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155029		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE (X3) DATE SURVEY COMPLETED 06/19/2012			
	PROVIDER OR SUPPLIEI NITY NURSING AN	RID REHABILITATION CENTER	5600 E	16TH ST NAPOLIS, IN 46218	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for		K0155 It is the practice of this provider to ensure that where a required fire alarm system is out of service for more than four hours in a 24 hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided		g
	accordance with order to protect			approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. What corrective action(s) will be taken for those residents found have been affected by the defici	to
	and Procedure" Maintenance Sureview from 9:2 06/19/12, Procedure report the fire. It designee will not entities." The far policy stated the jurisdiction, the of Health, would event of a fire.	documentation with the pervisor during record 5 a.m. to 11:25 a.m. on dure 6 states "Call 911 to The facility's ED or tify all necessary will be written fire watch authority having Indiana State Department only be notified in the Based on interview at the eview, the Maintenance		practice? A policy has been written contain procedures that are to be followe the event the fire alarm system is of service for more than 4 hours i 24 hour period. How will you identify other residents having the potential to be affected by the same deficient practice? All residents who reside in the fact have the potential to be affected this alleged deficient practice. What measures will be put into	d in out n a

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STATEMENT OF DEFICIENCIES X13		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DUIL DING	01	COMPLETED	
155029		155029	A. BUILDING		06/19/2012	
			B. WING	ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
		UD DELLABULTATION CENTED		16TH ST		
COMMU	NITY NURSING AF	ND REHABILITATION CENTER	INDIAN	NAPOLIS, IN 46218		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	Supervisor acknowledged the written fire			place or what systemic changes	3	
		es not state notification of		will you make to ensure that the		
	1 1			deficient practice does not recu	r?	
		e Department of Health	The Meintenan Dinester/De			
		the event the fire alarm		The Maintenance Director/Design will check all disaster manual	nee	
	system is out of	service for four hours or		locations 1 x monthly to ensure a	ılı İ	
	more in a 24 hor	ur period.		are in the appropriate locations w		
	3.1-19(b))			appropriate policies in place.		
				Fire Watch Policy and Proce	edure	
				Policy:		
				It is the policy of this Provider to		
				implement a firewatch in case of		
				emergency situations in which the		
				fire suppression system and/or th		
				fire alarm system are out of servi for a period of time longer than 4		
				hours in a 24-hour period.		
				It is the policy of this Provider to		
				implement a firewatch at other tir	nes	
				as determined by the Executive Director, Director of Nursing or		
				Maintenance Director as needed		
				With the implementation of any		
				Firewatch for any justifiable reason	on.	
				the Executive Director or designed		
				will notify all necessary entities to		
				include		
				a. State Department of Health		
				317-233-7442		
				b. Insurance Company (Con	nor	
				Insurance 317-808-77		
				c. Owners (via Director of		
				Operations/C.O.O.)		
				317-523-4786 d. Security Monitoring Comp	any	
				(Central Security) 317-543-1300	-	
				e. Local Fire		
				Department		
				911		
				f. Any other necessary entiti		
1				deemed necessary or required by	y	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155029	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 06/19/2012		
NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION		
	•			law. How the corrective action be monitored to ensure the deficient practice will not i.e. what quality assurant program will be put into	n(s) will he crecur, ce place? y the iew the o ensure		

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